Balance Disorder Questionnaire

Name _____ Date _____

Address _____

_____

Date of Birth _____ Phone #_____

Primary Care Physician _____ Referring Physician_____

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1) Briefly describe the problem you are encountering: _____

_____

_____

2) Have you consulted any other physician regarding your dizziness? Y N

If yes, please list and describe findings: _____

_____

3) Has any testing been performed to assist in the diagnosis?……Y N

If yes, please list: _____

Dizziness History

1) Is your dizziness a sensation of: (Please Circle)

a. Turning…… Y N
b. Lightheadedness……Y N
c. Disorientation……Y N
d. Loss of Balance…… Y N
e. Room Spinning…… Y N
f. Is your dizziness different than these listed?…… Y N

If yes, please describe: _____

_____

2) When did your dizziness begin? _____

3) Did it happen: Suddenly? Gradually?

4) Can you recall what you were doing when the dizziness first occurred?…… Y N

If yes, please describe: _____

_____

5) Was it accompanied by: Nausea? Vomiting?

6) Do you know of anything that may have caused or been related to your dizziness?…… Y N

If yes, please describe: _____

7) Is your dizziness: Continuous? Periodic?

8) Are you dizzy right now? ……Y N

9) When did the last attack occur? _____

10) Is the dizziness brought on or made worse by sudden movement or change in position? …Y N

If yes, please describe the positions and changes that take place: _____

_____

_____

11) How long does a typical attack last? _____

12) Have your symptoms changed over the past 6 weeks? _____

13) Rate your Dizziness on a scale of 1-10 (1 – no dizziness; 10 – worst): _____

14) Have you experienced any of the following:

a. Headache ……Y N
b. Pressure in head……Y N
c. Pressure in back or neck …… Y N
d. Numbness in face…… Y N
e. Blurred vision ……Y N
f. Fainting spell……Y N
g. Chest pain ……Y N
h. Loss of memory ……Y N
i. Difficult concentrating …Y N
j. Shortness of breath…… Y N
k. Loss of energy ……Y N
l. Fear of falling ……Y N
m. Tingling in face or hands…Y N

15) Are there any factors that make your dizziness worse? ……Y N

If yes, please describe: _____

16) Are there any factors that make your dizziness better? ……Y N

If yes, please describe: _____

Hearing

1) Do you have a hearing loss: ……Y N

If yes, please describe: _____

2) Did your hearing loss begin at the same time as your dizziness? ……Y N

3) Was your hearing loss: Sudden? Gradual?

4) Does your hearing fluctuate? ……Y N

5) Is there or have you had any pressure in your ears?.....Y N

6) Is there any pain in your ears?…… Y N

7) Have you had a history of ear infections? ……Y N

8) Have you had your hearing tested previously by an audiologist? ……Y N

If yes, what were the results? _____

_____

9) Do you wear hearing aids? ……Y N

If yes, what type: _____

General History

1) Have you ever had a head or ear injury?…… ……Y N

If yes, please answer the following questions:

a. Have you ever had surgery to your head or ears? ……Y N

b. Did you have a concussion? ……Y N

c. Were you knocked out (unconscious)? ……Y N

d. Did you feel dizzy? ……Y N

2) Have you been exposed to excessive noise (machinery, gunfire, etc.)? ……Y N

3) Have you now, or in the past, had any of the following illnesses?

a. Diabetes ……Y N

b. High Blood Pressure……Y N

c. Heart Disease ……Y N

d. Stroke ……Y N

e. Kidney Failure ……Y N

f. Glaucoma ……Y N

g. Mumps ……Y N

h. Measles ……Y N

i. High Fever ……Y N

j. Seizure Disorder ……Y N

k. Migraine Headaches ……Y N

4) Any other illnesses? _____

_____

5) Please list all medications you are taking: _____

_____

_____

Thank you for taking the time to fill out this questionnaire to enable us to serve you better!